SAMPLE CHAPTER FROM:

Intelligent Kindness

Reforming the Culture of Healthcare

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Introduction

For over 60 years, the National Health Service (NHS) has been a central feature of British life. From the cradle to the grave, citizens are promised healthcare, delivered according to need, free at the point of delivery. We look to it to protect our health, to help us bring our children into the world, to treat our illnesses, from the trivial to the life-threatening, and to care for us in our time of dying. We pay for it, of course, through taxation and National Insurance contributions. On our behalf, the government sets the priorities and standards for the NHS and regulates it, and allocates our money to local organisations and clinicians to manage and deliver our care.

In our view, what is important at the root of this arrangement is that all citizens are taking responsibility for one another. The public *share* the risks of accident and illness, the costs of caring for each other, the responsibility for the limits to the resources, and for setting the priorities relating to how the NHS develops. Although it is large and complex, and in obvious ways like an industry, it is, we think, much more than that. It is a by-no-means perfect arrangement that invites society to value and attend to its deepest common interest and connectedness. It is an expression of community, and one that can improve (in terms of quality and efficiency) if society, patients and staff can reconnect to and be helped to realise these deeper values.

We are aware that valuing these aspects of the British approach to public healthcare is controversial and can attract vehement opposition. It is not surprising that throughout its history the NHS has evoked powerful feelings in citizens and staff (who are citizens too) of gratitude, pride and protectiveness, and also of concern, disappointment and anger. Of course, the venture was political, and remains so – and this opens up questions and evokes strong feelings. The mainstream political parties in the UK are currently committed, at least publicly, to the NHS, but the range of ideologies and methodologies of 'reform' or 'transformation' often chime uncomfortably with the intention and power of the underlying vision.

Whatever its denigrators have said, the NHS has worked. The chronic under-resourcing (compared with healthcare expenditure in other industrialised countries) through the last decades of the 20th century had a

detrimental effect on treatments and outcomes for some conditions, but the country's overall health statistics in the second part of the 20th century compared well with those of similar countries (Pollack, 2004, pp. 40–41). Life expectancy remained consistently above the US and EU average and infant mortality rates were consistently lower, despite the fact that healthcare expenditure per capita was much less than the US or EU average and the UK spent much less on health as a percentage of gross domestic product (GDP), according to the Office of Health Economics (see Pollock, 2004, p. 35).

The Labour government brought spending up to the European average between 2002 and 2007, with large-scale increases in workforce, improved access to services and shorter waiting times, during a period when demand increased significantly. NHS healthcare environments improved, though by no means universally. Criticisms that this increased funding did not yield sufficient impact may hold water. Much of the investment found its way into pay awards, Private Finance Initiatives, reorganisations and successive forms of regulation and commissioning. But that is a criticism of government strategy, not of the NHS. Although the Conservative–Liberal Democrat coalition government since May 2010 has made much of poor comparisons between some health outcomes in the UK and those in some other industrialised countries, the trend of improvement shows that the NHS will soon equal or overtake their performance. This is true even though the UK spends 2.5 percentage points less of its GDP on healthcare than does, for example, France (Appleby, 2011).

Let us accept from the start that no approach is perfect. Individuals do face limits to what the state, husbanding limited resources on our joint behalf, will and can fund – whether it be new drugs or treatments, new hospitals or more staffing. A universal, comprehensive, system requires steering, commissioning, regulating and managing on a grand scale. The system can foster unhelpful dependency and a lack of personal responsibility for health. Citizens, and workers within the NHS, can both develop a sense of passive (and sometimes aggressive) entitlement to their services or ways of working and jobs.

Priorities are often hard to agree on, especially with the rapid rise in the ageing population and with the development of new treatments and health technologies, and even harder to reconcile locally. These priorities can be skewed by public panic, interest groups who shout loudest, ideas about most (and least) deserving groups, media campaigns, stigma and denial. Our public investment in healthcare can be vulnerable to wider events – war, recession, crime and the costs of other public priorities. Just how much, anyway, should we, as a population, require our government to invest on our behalf in health and healthcare? Up to what standards and with what priorities? How much tax are we willing to pay in any case? The continued existence of the NHS depends on voters being confident that it is worth their while to invest their 'healthcare insurance' in taxes – and this is hard to judge, both for individuals and for society.

Nonetheless, we believe that the NHS is the best way to go about securing the healthcare of a civilised society. Struggling with the inevitable difficulties in such a model is worth it. It means universal free access to healthcare and a commitment to the ethical and systematic organisation of resources to provide it. But it also embodies society's pooled investment in its collective well-being, shared risk and shared responsibility for each other, making the NHS one of the most socially valuable of all institutions. Although our book focuses on UK healthcare, many of the ideas we explore are, we believe, applicable beyond that arena – to healthcare systems in other countries, and to social care.

We have worked in the NHS – in clinical and leadership roles – for many years. We have cared for people, supervised and trained staff, managed budgets, delivered savings and reshaped services. We have developed strategy and managed change. In our work, we have made mistakes and done things we are proud of. We have been patients, needing care and services from many parts of the healthcare system at different times in our lives. We have supported children, friends and elderly relatives through healthcare at times of accident, illness and dying. We have had varied experiences in all these roles – some apparently relating to 'the system' and some to the attitudes and skills of staff. It has frequently been difficult to tell the difference.

We accept that the project of delivering an efficient, effective and high-quality NHS requires a form of management that will inevitably include a range of ideologies and techniques. The scale and elaborateness of the approach, the models and methods used, and the way services are led and managed require careful judgement. Despite their successes, we have not, overall, been impressed by many of the realities of the implementation of the Labour government's 'reform' project and fear that changes under the coalition government's Health and Social Care Bill will undermine the NHS even further.

More importantly, we are concerned that so little attention has been given to understanding and promoting what we see as central to the NHS enterprise as a whole: its embodiment of *kinship*, and its expression in the *compassionate relationship* between the skilled clinician and the patient. To fail to attend to the promotion of kinship, connectedness and kindness between staff and with patients is to fail to address a key dimension of what makes people do well for others. Such failures can sometimes be no more than minor irritations, but they can lead to appalling systemic abuses, neglect and maltreatment – as evidenced in successive reports of inquiries into the care of the elderly (Health Services Ombudsman, 2011), people with intellectual disabilities (Michael, 2008) and several acute healthcare trusts (Healthcare Commission, 2007, 2009). All such scandals immediately raise in the public mind disturbing questions about how compassion can fail. And yet that question receives far less attention in subsequent corrective action than it deserves. We think these questions require much more thorough investigation. Abuses can, and do, happen in public and private healthcare

services: the exploration in this book seeks to shed light on some of the factors leading to failures in compassion, especially in the NHS in the UK.

The absence of attention to the question of kindness is particularly disturbing because we see the NHS project itself as an expression of kinship and common interest in the face of risk, danger and death. What is more likely to ensure that everybody strives to make it work than paying attention to how to engage people in that value-based vision and supporting them in making it real? What is more likely to motivate people to address inequalities and to champion people's rights?

We believe that putting a fraction of the effort that has gone into processes of organising, regulating and industrialising the NHS into developing our understanding of what helps and hinders kindness in its staff would have enormous ramifications for effectiveness and efficiency, as well as for the experience of the patient. If we were to apply that understanding intelligently to the way we run things, our public hopes and expectations for the service would be far more likely to be met. It may be unavoidable that we have, some of the time, to consider and frame healthcare from a transactional, commodified, industrial and value-for-money perspective. We argue, however, that to undervalue attention to NHS healthcare as a commitment to the skilled and effective expression of fellow feeling and kindness, through the relationship between staff and patient, is dangerous. It will lead to waste and poor performance, to low morale and poor patient satisfaction, to continued shameful abuses.

There is, perhaps surprisingly, a substantial body of knowledge to shed light on the subject of what kindness is, and what managing to be kind is about. This knowledge relates to the attitudes and behaviour of individuals, to teams and groups, to organisations and to society. It illuminates our understanding of why things go wrong, of why people behave unkindly, and also what conditions promote kindness and consequent well-being. It shows direct links between kindness and effectiveness and positive outcomes. It suggests virtuous circles where kindness promotes well-being, reduces stress and increases satisfaction for the patient, the worker and the organisation.

We are not suggesting yet another labyrinthine 'national programme'. Nor are we proposing some sentimental crusade. We do not advocate a 'technology of kindness'. But what if this body of knowledge were to be used to develop our understanding about how to reform, improve and ensure the quality and value for money of health services? What if we understood better how to bring out, nurture and protect kindness and its related attentiveness to what others need? What if people were educated, trained and managed to bring this understanding into practice, whether as policy makers, managers or clinical staff?

This book is an experiment with this approach. We hope it offers an impetus to the process of mustering the knowledge, arguments and evidence to develop this alternative view of reform. We hope it will go some way to

justify priority being given to tempering the more mechanical and industrial reform programme through the intelligent promotion of kindness.

Our book is not an attempt to provide an encyclopaedic coverage of the subject. The aim is to offer sufficient argument and illustration, to raise questions and to indicate further directions for the general reader, for student clinicians and practitioners, and for people working in healthcare at every level. To develop the paradigm that we imagine would need the collaboration of a lot of people – just as the elaborate regulation and structural change agenda has required. They exist – the specialists in various forms of knowledge and skills, and the ordinary (and extraordinary) people working in the system who, we believe, would thrive better were they to be invited into ways of working indicated by an understanding of kindness. If our book can engage people's curiosity, promote some confidence that the approach is worth pursuing and sketch some of the landscape that requires exploring, we will have achieved our purpose. We should say from the start that we believe passionately in the NHS, and know that there is much that is excellent, kind and effective in the work of the 1.3 million staff who contribute their intelligence, skills and effort. If we address some of its problems and failures directly, it is to advance our argument that there is a way of dealing with them based on applying what can be understood about kindness. We do not want to denigrate the widespread excellence of the work of hosts of dedicated people.

This book is *not* about sentimental niceness or simple altruism. As our opening chapter will attest, kindness is something that is generated by an intellectual and emotional understanding that *self-interest and the interests of others are bound together*, and by acting upon that understanding. Human beings have enormous capacity for kindness, but also for destructiveness and violence. We make no apology for spending time examining some of the roots and causes of *unkindness*, with a view to illuminating how best to promote and nourish kindness in the work of healthcare staff. Whether politics are striving to create the Big Society, the Good Society, or any other vision of national well-being, the strategies adopted will mean little unless they promote positive emotional engagement and the intelligent application of skills and resources, to manage darker impulses well.

Aspects of kindness appear in various forms across healthcare policy in the UK, which is to be celebrated. There is, though, a frequent sense that it is the junior partner alongside other ideologies and goals, leaning over the shoulder of more important things. Whether kindness is helped or hindered by these other aspects of policy and reform is seldom considered. We aim to bring kindness into the foreground in the crowded company of policies and technologies for NHS reform and to do it the justice of examining some of the ways it is helped and hindered by its fellows.

Finally, a note on our use of words. We have chosen to use the expression 'patient' throughout this book. This is because we want to stress the link with compassion – a patient is someone we 'feel (or even suffer) with'. We

are aware that the focus on suffering could be regarded as reinforcing the unhelpful idea that patients are passive victims – but we believe that people's strengths are more readily inspired when they feel that their suffering is recognised and understood. We are all patients – of our general practitioners at the very least – whether we are ill or not, whether we 'use services' or not. Citizens may, rightly, need the power to exercise choice, even, at times, to be empowered as 'customers', but, above all, they need and deserve a compassionate, skilled response to their suffering.

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